2015 Comparison of State of Iowa Retirees Health Insurance Plans

October-14	Managed Care Organization (MCO) Plans Blue Access Blue Advantage	Preferred Provider Organization (PPO) Plans Gold Preferred	 Iowa Select	Indemnity Plans Program 3 Plus	 Deductible 3 Plus
General Plan Provisions					
Benefits Available from Non-Participating Providers *You are responsible for any amounts between the billed charge and the maximum allowable fee paid by Wellmark. These amounts will not accumulate towards the medical out-of-pocket limit.*	None, unless prescribed and referred by a participating physician and approved by Wellmark, or in an emergency medical situation.	Normal plan benefits for network/non-network providers	Normal plan benefits for network/non-network providers	Normal plan benefits	Normal plan benefits
Deductible *Family deductible is reached from amounts accumulated on behalf of any family member or combination of family members.*	None	$750 Single $1,500 Family Applies to services provided both in- and out-of-network. All deductibles, coinsurance, and copayments, go toward out-of-pocket limit. (Separate out-of-pocket limit for prescription drugs.)	$250 single network/non-network $500 family network/non-network Applies to both inpatient and outpatient services.	$300 single $400 family Inpatient services only. The entire family deductible must be met before benefits payments are made.	$300 single $400 family Applies to most services. The entire family deductible must be met before benefits payments are made.
Medical Out-of-Pocket Maximum *Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members.*	$750 Single $1,500 Family All copayments go toward out-of-pocket limit with the exception of prescription drug copayments.	Single: $1,500. Family: $3,000 All health deductibles and coinsurance go toward the health out-of-pocket limit	$600 Single $800 Family Applies to services provided both in- and out-of-network. All health deductibles, and coinsurancego toward the health out-of-pocket limit. (Separate out-of-pocket maximum for prescription drugs)	$600 Single $800 Family All health deductibles and coinsurance go toward the health out-of-pocket limit (Separate out-of-pocket maximum for prescription drugs)	$600 Single $800 Family All deductibles and coinsurance go toward out-of-pocket limit.
Lifetime Benefits Maximum	None	None	None	None	None
Preexisting Condition Waiting Period	None	None	None	None	None
Preventive Services					
Affordable Care Act (ACA) preventive services	Affordable Care Act (ACA) required preventive services do not apply	Covered at 100% per ACA guidelines. Preventive care from participating providers with Wellmark is not subject to the deductible or coinsurance.	Affordable Care Act (ACA) required preventive services do not apply	Affordable Care Act (ACA) required preventive services do not apply	Affordable Care Act (ACA) required preventive services do not apply
Professional Office Services					
Office Visit	$10 copay	$20 copay for primary care physician (PCP) $40 copay for specialists Once per date of service for exam only	$15 copay Once per date of service for exam only Other office services: Network 10%, deductible waived Non-network 20%, after deductible	$15 copay Once per date of service for exam only Other office services: 20% no deductible	20%, after deductible
Allergy Testing	$10 copay	Network 20%, deductible waived in office Non-network 30%, after deductible	Network 10%, deductible waived Non-network 20%, after deductible	20%, no deductible	20%, after deductible
Allergy Serum and Injections	$10 copay	Network 20%, deductible waived in office Non-network 30%, after deductible	Network 10%, deductible waived Non-network 20%, after deductible	20%, no deductible	20%, after deductible
Chiropractic Services	$10 copay, if approved Blue Advantage - 12 self-referred visit limit to a Chiropractor	$20 copay for exam only Network 20% deductible waived in office Non-network 30% after deductible	$15 copay for exam only Network 10%, deductible waived Non-network 20%, after deductible	$15 copay for exam only 20%, no deductible	20%, after deductible
Routine Eye Exam	$10 copay	$40 copay	$15 copay exam only	Not covered	Not covered
Routine Hearing Exam	$10 copay	$40 copay	$15 copay exam only	Not covered	Not covered
Surgery, Radiology & Pathology (office)	$10 copay	Network 20%, deductible waived in office setting Non-network 30%, after deductible	Network 10%, deductible waived Non-network 20%, after deductible	Surgery 0%, no deductible Radiology & Pathology related to surgery 0%, no deductible Radiolofy & Pathology non-surgery related 20%, no deductible	0% after deductible
Hospital Services					
Inpatient Hospital Services					
Preapproval of Inpatient Admissions	Required	Required	Required	Required	Required
Inpatient Hospital Services	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10% after deductible Non-network 20% after deductible	20%, after deductible	20% after deductible
Outpatient Hospital Services					
Ambulatory Surgical Center	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10% after deductible Non-network 20% after deductible	20%, no deductible	0% after deductible

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Outpatient Diagnostic Lab, Radiology	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10%, after deductible Non-network 20%, after deductible	0%, no deductible	0% after deductible
Emergency Care					
Ambulance	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10% after deductible Non-network 20% after deductible	20% no deductible	20% after deductible
Urgent Care Center	0%	Network 20%, after deductible Non-network 30%, after deductible	Network 10% after deductible Non-network 20% after deductible	20% no deductible	20% after deductible
Hospital Emergency Room	$50.00 copayment; waived if admitted.	$50.00 copay; waived if admitted. Deductible and 20% coinsurance apply.	$50.00 copayment; waived if admitted 10% after copayment	0% no deductible	0% after deductible
Behavioral Health Services					
Inpatient mental health and substance abuse treatment	0%	Network 20% after deductible Non-network 30% after deductible	Network 10% after deductible Non-network 20% after deductible	20% after deductible	20% after deductible
Outpatient mental health and substance abuse treatment	$0	$0 copayment	$0 copayment	$0 copayment	0% after deductible
Outpatient Therapy Services					
Chemotherapy Physical Therapy Occupational Therapy Respiratory Therapy Speech Therapy	$10 copayment per visit 60 visit limit for each of the following services: Physical Therapy (excluding Chiropractic) Occupational Therapy Respiratory Therapy Speech Therapy	Network 20% after deductible Non-network 30% after deductible	Network 10% after deductible Non-network 20% after deductible	20% no deductible	20% after deductible
Prescription Drug Coverage					
Deductible	No deductible	$100 (waived for generic drugs)	No deductible	No deductible	No separate deductible
Pharmacy Out-of-Pocket Maximum	No out-of-pocket maximum. Copayments do **NOT** apply to medical out-of-pocket maximum.	Single $5,100 Family $10,200 Copayments do **NOT** apply to medical out-of-pocket maximum.	Single $250 Family $500 Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. Prescription drug out-of-pocket does not apply to medical out-of-pocket limit.	Single $250 Family $500 Family out-of-pocket is reached from amounts accumulated on behalf of any family member or combination of family members. Prescription drug out-of-pocket does not apply to medical out-of-pocket limit.	No separate out-of-pocket maximum
Retail	30-day supply for maintenance and non-maintenance drugs 90-day supply for maintenance drugs.	30-day supply for maintenance and non-maintenance drugs 90-day supply for maintenance drugs.	30-day supply for maintenance and non-maintenance drugs 90-day supply for maintenance drugs.	30-day supply for maintenance and non-maintenance drugs 90-day supply for maintenance drugs.	30-day supply
Tier 1 Medications	$5 copay - 30-day supply	$10 copay - 30-day supply	$5 copay - 30-day supply	$5 copay - 30-day supply	20%, after deductible
Tier 2 Medications	$15 copay - 30-day supply	$25 copay - 30-day supply	$15 copay - 30-day supply	$15 copay - 30-day supply	
Tier 3 Medications	$30 copay or 25%*- 30-day supply *whichever is greater	$50 copay - 30-day supply	$30 copay for a 30-day supply	$30 copay for a 30-day supply	
Tier 4 Medications	Same as Tier 3	$100 copay - 30-day supply	Same as Tier 3	Same as Tier 3	
Mail Order	90-day supply for maintenance drugs only	90-day supply for maintenance drugs only	90-day supply for maintenance drugs only	90-day supply for maintenance drugs only	Mail order not available
Tier 1 Medications	$10 copay	$20 copay	$10 copay	$10 copay	
Tier 2 Medications	$30 copay	$50 copay	$30 copay	$30 copay	
Tier 3 Medications	$60 copay	$100 copay	$60 copay	$60 copay	
Tier 4 Medications	$60 copay	$200 copay	$60 copay	$60 copay	
Prescription Drug Coverage - General Information					
Prescription Drugs/Items for Smoking Cessation	Not Covered	Covered	Not Covered	Not Covered	Not Covered
		In most cases, when you purchase a brand name drug that has an FDA-approved "A"- rated generic equivalent, Wellmark will pay only what it would have paid for the equivalent generic drug. You will be responsible for your payment obligation for the equivalent generic drug and any remaining cost difference up to the maximum allowed fee for the brand name drug.			

Important Information:
This document provides a general summary of the basic benefit provisions and is not a substitute for the Benefit Booklet. If there are any inconsistencies between this summary and the benefit Booklet will prevail. Please refer to the Benefit Booklet for exact benefits, exclusions, and limitations or contact Wellmark's customer service at 800.622.0043.